

# Kindergarten Registration Requirements

As stated in the Delaware Valley School Policy, your child(ren) must be five (5) years old on or before September 1 to attend Kindergarten in that school year.

**Kindergarten Registration and screening is by appointment at your child's school in the Spring. Registration appointments will be made after your paperwork is turned in.**

**YOUR CHILD WILL NOT BE PUT ON OUR KINDERGARTEN REGISTRATION LIST UNTIL THE FOLLOWING PAPERS ARE TURNED IN.**

## REQUIRED REGISTRATION DOCUMENTS:

### 1. ORIGINAL BIRTH CERTIFICATE

The official state seal must be affixed to the birth certificate.  
(Your original will be copied and returned to you.)

### 2. CURRENT DOCTOR'S RECORD OF CHILDHOOD IMMUNIZATIONS

If incomplete, updates can be turned in over the summer but the current record needs to be turned in now. The following **compulsory** immunizations must be completed for your child to start school:

- **At least 4 doses of Diphtheria, Tetanus, Pertussis (Dtap), with the 4<sup>th</sup> dose on or after the 4th birthday**
- **4 doses of Polio with the 4<sup>th</sup> dose on or after 4<sup>th</sup> birthday AND at least 6 months after previous dose**
- **2 doses of Measles, Mumps & Rubella**
- **3 doses of Hepatitis B (spaced according to PA DOH guidelines)**
- **2 doses of varicella immunization or verification of chicken pox disease**

### 3. TWO FORMS OF PROOF OF RESIDENCY

**Two** forms are required. Homeowners must provide current Real Estate or School Tax Form, Renters must provide either a Lease or the landlord's current Real Estate or School Tax Form accompanied with the enclosed, signed, Landlord Affidavit. The second proof should be a utility bill with matching legal parent/guardian name and address.

### 4. PROOF OF PARENT/GUARDIAN IDENTITY

This must be a photo ID of the legal parent/guardian(s) (for example a Pennsylvania Driver's license) indicating the address corresponding with the address on the proof of residency.

### 5. CUSTODY & GUARDIANSHIP PAPERS

Any court documents or formal agreements explaining custody arrangements should be turned in for us to make a copy. If the child resides with a grandparent or relative, Guardianship papers are required. Prospective guardian(s) must attend a mandatory meeting with the Building Principal and complete guardianship papers. (Any court documents or formal agreements explaining this custody arrangement.)

### 6. COMPLETED REGISTRATION PACKET

Student Registration Form, Health Registration Form, Nurse's Developmental History, Teacher's Registration Form, Acceptable Use User's Agreement, Home Language Survey, and Bussing Form, are to be completed, signed by parent where requested and turned in to your child's school before Spring Registration, or turned in to Support Services during summer registration.

(The Doctor signed physical and dental forms can be turned in now or over the summer if needed.)

**PLEASE Contact your child's school directly to find out when and how they would like you to turn in your Registration packet and documents.**

Delaware Valley Elementary School office: Larissa McLean at 570-296-1823, email: [LMcLean@DVSD.org](mailto:LMcLean@DVSD.org)  
Dingman Delaware Primary School office: Stacy Rutherford at 570-296-3132, email: [SRutherford@DVSD.org](mailto:SRutherford@DVSD.org)  
Shohola Elementary School office: Laura Lamberton 570-296-3603, email: [LLamberton@DVSD.org](mailto:LLamberton@DVSD.org)  
Support Services, Summer enrollment office: Carol Ann Dardia (570) 296-1889, email: [CDardia@DVSD.org](mailto:CDardia@DVSD.org)

# KINDERGARTEN STUDENT REGISTRATION

School ID#: \_\_\_\_\_

Today's Date: \_\_\_\_\_ Student Birth Date: \_\_\_\_\_ Gender: \_\_\_\_\_

Student Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_

Previous school grade (circle one): Pre-K K None School Phone number: \_\_\_\_\_

Previous school Name: \_\_\_\_\_

Ethnic Origins (circle one): White Black Hispanic Asian Pacific Islander  
(If multi-racial circle two) American Indian/Alaskan Native

Home Phone: \_\_\_\_\_

Student lives with: \_\_\_\_\_

Physical Address: \_\_\_\_\_ Mailing Address: \_\_\_\_\_

\_\_\_\_\_  
(City, State, ZIP)

\_\_\_\_\_  
(City, State, ZIP)

-----  
**Primary Parent/ Legal Guardian 1<sup>st</sup> contact:**

Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Signature: \_\_\_\_\_

-----  
**Secondary Parent/Legal Guardian 2<sup>nd</sup> contact:**

Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Lives with Child: \_\_\_ Yes, \_\_\_ No, \_\_\_ Partially

-----  
Doctor Name and Phone Number: \_\_\_\_\_

Non-Custodial Parent Name, Address, & Phone Number: \_\_\_\_\_

-----  
Guardian/Custody Alert (Please bring legal documentation to Registration): \_\_\_\_\_

-----  
**FOR OFFICE USE ONLY**

- \_\_\_ Birth Certificate
- \_\_\_ Immunizations
- \_\_\_ Proof of Residency
- \_\_\_ Proof of Identity
- \_\_\_ Guardianship Papers
- \_\_\_ Home Language Survey

Previous PA School ID #: \_\_\_\_\_

Special Ed: Y \_\_\_\_\_ N \_\_\_\_\_ Trans. \_\_\_\_\_

Photo/Video: Y \_\_\_\_\_ N \_\_\_\_\_

Internet Usage: Y \_\_\_\_\_ N \_\_\_\_\_

Enrollment Code: \_\_\_\_\_ Enrollment Date: \_\_\_\_\_

**DELAWARE VALLEY SCHOOL DISTRICT  
MILFORD, PENNSYLVANIA 18337  
HEALTH REGISTRATION FORM**

Date of Entry \_\_\_\_\_  
Grade \_\_\_\_\_

Teacher \_\_\_\_\_  
School \_\_\_\_\_

Dear Parent:

When your child enters school, we establish a cumulative record file on him/her to enable us to have a greater understanding of your child's needs. All information, of course, will be kept strictly confidential, so please answer every question. Birth certificate and Immunization Record must be presented at registration.

PLEASE PRINT NEATLY. Thank you for your cooperation.

Has your child ever attended school in DVSD? \_\_\_\_\_  
If yes, what grade? \_\_\_\_\_

Pupil's Name \_\_\_\_\_

Mailing Address \_\_\_\_\_  
No. Street

Home Telephone No. \_\_\_\_\_

Town State Zip Code  
Community or Road \_\_\_\_\_

Birthdate \_\_\_\_\_ Birthplace \_\_\_\_\_

Last School Attended: \_\_\_\_\_ City or Town: \_\_\_\_\_ Grade: \_\_\_\_\_

Father or Male Guardian	Mother or Female Guardian Name
Name	
Relation to Child	
Occupation	
Cell Phone	
Work Phone	
Email	

Child lives with: Both Parents \_\_\_\_\_ Father \_\_\_\_\_ Other person \_\_\_\_\_ (name & relationship to student)  
Language spoken in home \_\_\_\_\_

**OTHER CHILDREN IN FAMILY**

Name	Birthdate	School	Name	Birthdate	School

If parent is not available in Emergency, call:

1. \_\_\_\_\_
2. \_\_\_\_\_

Physician to be called in Emergency: \_\_\_\_\_  
Name Address Phone No.

**DISEASE & HEALTH HISTORY**

Asthma or Bronchitis: \_\_\_\_\_  
Foods, Drugs, Hay Fever, Grasses, Animals – PLEASE BE SPECIFIC: \_\_\_\_\_  
Any Hospitalization, stitches or fractures? \_\_\_\_\_

Family History of Color Blindness: \_\_\_\_\_ If yes, whom? \_\_\_\_\_  
Eye Glasses Yes \_\_\_\_\_ No \_\_\_\_\_ Contacts Yes \_\_\_\_\_ No \_\_\_\_\_  
It is advised that every child wearing eye glasses should receive periodic eye examinations. The school would appreciate a report of exam and name of examiner together with any recommendations for school.

Does your child have any other medical conditions? Yes \_\_\_\_\_ No \_\_\_\_\_

List: \_\_\_\_\_

Does your child take any medication? Yes \_\_\_\_\_ No \_\_\_\_\_ If so please list \_\_\_\_\_

Will your child need to take medication at school? Yes \_\_\_\_\_ No \_\_\_\_\_ Please list: \_\_\_\_\_

Do you have health insurance for your child? Yes \_\_\_\_\_ No \_\_\_\_\_

DELAWARE VALLEY SCHOOL DISTRICT  
NURSE'S DEVELOPMENTAL HISTORY

Name of Child: \_\_\_\_\_ Birthdate: \_\_\_\_\_

A child's development since birth influences his/her total health and growth. Please answer the following questions:

History of Birth:

1. Mother's age at child's birth: \_\_\_\_\_
2. Were there any unusual conditions during pregnancy (i.e. bleeding, infection, German Measles, medication, high blood pressure)? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If yes, which illness and when did illness occur? \_\_\_\_\_
3. Was the baby premature? \_\_\_\_\_ at what month was baby delivered? \_\_\_\_\_
4. What was the baby's weight at time of birth? \_\_\_\_\_
5. Was delivery normal? \_\_\_\_\_ Forceps delivery? \_\_\_\_\_ C-Section? \_\_\_\_\_  
If C-Section, why? \_\_\_\_\_
6. Were there any conditions or problems in the child after birth (i.e. Jaundice, need for oxygen, birth injuries, or birth defect?) \_\_\_\_\_ Comment \_\_\_\_\_
7. Was the labor difficult? \_\_\_\_\_ How long was labor? \_\_\_\_\_
8. RH factor or any other blood problem? \_\_\_\_\_
9. Apgar at 1 minute \_\_\_\_\_ at 5 minutes \_\_\_\_\_

History of Infancy and Childbirth:

Has your child shown any of the following? (Answer Yes or No)

- |  |       |                |
|--|-------|----------------|
| 1. Extreme Activity  | _____ | Comment: _____ |
| 2. Extremely Tired/Sleepy  | _____ | Comment: _____ |
| 3. Frequent Headaches  | _____ | Comment: _____ |
| 4. Temper Tantrums   | _____ | Comment: _____ |
| 5. High Fevers   | _____ | Comment: _____ |
| 6. Fainting  | _____ | Comment: _____ |
| 7. Convulsions/Seizures  | _____ | Comment: _____ |
| 8. Feeding Problems  | _____ | Comment: _____ |
| 9. Bowel/Bladder Problems  | _____ | Comment: _____ |
| 10. Allergies  | _____ | Comment: _____ |
| 11. Frequent Stumbling/Falling   | _____ | Comment: _____ |
| 12. Poor Coordination  | _____ | Comment: _____ |
| 13. Nail Biting  | _____ | Comment: _____ |
| 14. Eye Blinking   | _____ | Comment: _____ |
| 15. Stuttering   | _____ | Comment: _____ |
| 16. Bed Wetting  | _____ | Comment: _____ |
| 17. Thumb Sucking  | _____ | Comment: _____ |
| 18. Other Habits/Problems  | _____ | Comment: _____ |
| 19. Any Injury to Eyes/Head/Neck   | _____ | Comment: _____ |
| 20. Any Hospitalizations   | _____ | Comment: _____ |
| 21. Any family history of birth defects  | _____ | Comment: _____ |
| Disorders, heart disease, diabetes, TB?  | _____ | Comment: _____ |
| 22. Has your child been to any clinic or other agencies?   | _____ | Comment: _____ |
| 23. At what age did your child first sit alone _____, walk along _____, crawl _____, said single words _____, talking _____, sentences _____, first tooth _____, bowel trained _____, bladder trained _____. |       |                |
| 24. Is there any other pertinent health information we should be advised of?   | _____ |                |

# Delaware Valley School District

## Teacher's Kindergarten Registration Information

Pupil's Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Birthdate: \_\_\_\_\_

### **General Information**

1. Does your child have the opportunity to play with children his/her own age? (please circle) Yes / No
2. Is your child able to dress himself/herself? (Tie shoes, zipper, buttons, etc.)

Comment: \_\_\_\_\_

3. Which hand is used for (please circle):

Eating: Left / Right

Writing: Left/ Right

Playing: left/ Right

4. Does your child use (please circle):  
Crayons: Yes/ No    Scissors: Yes/ No    Glue: Yes/ No  
Clay: Yes/ No    Blocks: Yes/ No

5. What time does your child go to bed at night: \_\_\_\_\_ To Sleep: \_\_\_\_\_

6. Does your child still take naps (please circle): Yes/ No

7. Are there any home/neighborhood problems/situations which may affect your child at school? Yes/ No

If yes please comment: \_\_\_\_\_

8. Do you read to your child? Yes/ No    Comment: \_\_\_\_\_

9. Does your child listen to and carry out directions? Yes/ No

10. Does your child have any strong fears (thunder, dark places, etc.)?

Comment: \_\_\_\_\_

11. Is there a computer/iPad in the home: Yes/ No    Does your child use the computer/iPad: Yes/ No

12. Is there additional information you can give about your child which could help us make his/her first year at school pleasant and successful? (Please use other side to comment if needed.)

\_\_\_\_\_  
\_\_\_\_\_

### **Previous Schooling**

13. Did your child attend preschool? Yes/ No    Where? \_\_\_\_\_

14. Did your child have early intervention through CDD (Center for Developmental Disabilities)? Yes/ No

Has your child/family had a BSC (Behavior Specialist) or TSS (Therapeutic Support Staff) during

15. preschool? Yes/ No

*Any information you can provide to better assist your child in the school learning environment is greatly appreciated. We want a smooth transition and the best opportunity for your child.*

# DELAWARE VALLEY SCHOOL DISTRICT

## PUBLICITY RELEASE FORM

Student Name: \_\_\_\_\_

School and Grade: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

I give my permission to use my son's/daughter's name and picture for **ALL** the media categories listed below:

District Website  
District Social Media  
District Brochures  
District Publications/Yearbooks  
District Scoreboards  
Student of the Month/Student Awards  
Newspaper Publications  
Newsletters  
Radio/TV

**YES** \_\_\_\_\_ **NO** \_\_\_\_\_

**Non-return of this form indicates approval to use your student's name and picture.**

It is the district's practice to involve students in positive activities that promote individual self-esteem and cooperation among our students.

Questions or concerns may be directed to: \_\_\_\_\_

Administrator

\_\_\_\_\_  
Telephone Number

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Parent/Guardian

Please print \_\_\_\_\_  
Parent/Guardian Name



# HOME LANGUAGE SURVEY

**ALL newly registering students regardless of race, nationality, or language origin MUST complete this form.** Federal law requires that all Local Education Agencies (LEAs) utilize a non-biased procedure for identifying which students are potential English Learners (ELs) in order to provide appropriate language instruction educational programs and services. Given this responsibility, LEAs have the right to ask for the information contained on this and other forms associated with the identification process.

**Student Information: Parents/Guardians should complete this section.**

Child's first name: \_\_\_\_\_

Child's last name: \_\_\_\_\_

Child's Date of Birth: \_\_\_\_\_

Current grade: \_\_\_\_\_ School of Enrollment: \_\_\_\_\_

**Questions for Parents/Guardians: Please answer all three questions.**

1. Is a language other than English spoken in the child's home?  No  Yes (language) \_\_\_\_\_
2. Does your child communicate in a language other than English?  No  Yes (language) \_\_\_\_\_
3. What is the language that your child first learned to speak? \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Interpreter Provided  No  Yes

The school district has the responsibility under the federal law to serve students who are limited English proficient and need English Language Development (ELD) services. Given this responsibility, the school district has the right to ask for the information it needs to identify English Learners (ELs). As part of the responsibility to identify ELs, the school district may conduct screenings or ask for related information about students who are already enrolled in the school as well as from students who enroll in the school district in the future.

For Office Use Only:

Date Received: \_\_\_/\_\_\_/\_\_\_

ELD Staff Member: \_\_\_\_\_

\_\_\_\_\_

**DELAWARE VALLEY  
SCHOOL DISTRICT**

**ADMINISTRATIVE REGULATION**

**REVISED: 8/6/2013**

**Acceptable Use of the Communications and Information Systems**

**USER AGREEMENT**

**ACKNOWLEDGMENT AND CONSENT FORM**

**Students**

I have received, read, and understand the Acceptable Use of Communications and Information Systems Policy# 815 and will comply with them. My parent(s)/guardian(s) have also reviewed it with me. In addition, I have been given the opportunity to obtain information from the School District and my parent(s)/guardian(s) about anything I do not understand. If I have further questions, I will ask my building principal and my parents. Additionally, I understand that if I violate the Policy, other School District policies, regulations, rules, or procedures, I am subject to the School District's discipline, and could be subject to ISP and website rules, and local, state and federal rules and procedures.

Name of Student .....

Signature of Student \_\_\_\_\_

Date of Signature \_\_\_\_\_

**Parent(s)/Guardian(s)**

As the parent/guardian of a student of the School District, I have received, read, and understand the Acceptable Use of the Communications and Information System Policy# 815. In addition, I reviewed the Policy with my child and answered questions he or she asked. If either my child or I have further questions I will ask the building principal. I agree to have my child comply with the requirements of this Policy, other School District policies, regulations, rules, and procedures. Additionally, I understand that if he or she violates the Policy, other School District policies, regulations, rules, or procedures he or she is subject to the School District's discipline, ISP and website rules, as well as local state and federal laws and procedures.

Name of Parent .....

Signature of Parent \_\_\_\_\_

Date of Signature \_\_\_\_\_

**DELAWARE VALLEY  
SCHOOL DISTRICT**

**ADMINISTRATIVE REGULATION**

**ADOPTED: AUGUST, 2025**

**USER AGREEMENT**  
**ACKNOWLEDGMENT AND CONSENT FORM**  
**PRIVACY AND SECURITY OF STUDENT ELECTRONIC AND DIGITAL INFORMATION**

**Parent(s)/Guardian(s)**

As the parent/guardian of a student of the School District, I have received, read, and understand the Privacy and Security of Student Electronic and Digital Information Policy # 820. In addition, I provide consent as required per FTC COPPA regulations for third parties. I have reviewed the School District provided list of third-party applications and websites. If I have further questions I will ask the building principal.

Name of Student \_\_\_\_\_

Name of Parent \_\_\_\_\_

Signature of Parent \_\_\_\_\_

Date of Signature \_\_\_\_\_



**DELAWARE VALLEY SCHOOL DISTRICT**  
**PRIVATE PHYSICIAN'S REPORT OF**  
**PHYSICAL EXAMINATION OF A PUPIL OF SCHOOL AGE**

Name of School \_\_\_\_\_ Grade \_\_\_\_\_ Homeroom \_\_\_\_\_

Name of Child \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex: M F

**PLEASE ATTACH CURRENT IMMUNIZATION RECORD FROM DOCTOR OR CLINIC**

Medical History (if yes, explain)

Allergies ----- Y N \_\_\_\_\_ Hypertension-----Y N \_\_\_\_\_  
 Asthma----- Y N \_\_\_\_\_ Neuromuscular Disorder -----Y N \_\_\_\_\_  
 Cardiac----- Y N \_\_\_\_\_ Orthopedic Condition----- Y N \_\_\_\_\_  
 Drug/Alcohol Dependency---- Y N \_\_\_\_\_ Respiratory Illness-----Y N \_\_\_\_\_  
 Diabetes-----Y N \_\_\_\_\_ Seizure Disorder----- Y N \_\_\_\_\_  
 Gastrointestinal Disorder-----Y N \_\_\_\_\_ Skin Disorder-----Y N \_\_\_\_\_  
 Hearing Disorder-----Y N \_\_\_\_\_ Vision Disorder-----Y N \_\_\_\_\_  
 Other (specify) -----Y N \_\_\_\_\_

Please list any special medical problems or medications the student takes.

**PHYSICAL EXAM**

Height \_\_\_\_\_ Weight \_\_\_\_\_ BMI \_\_\_\_\_ Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_

System	Normal	Abnormal	Deferred	Comment/Screening Result		
Hair/Scalp						
Skin						
Eyes & Vision Screening				OD	OS	REFER
Ears & Hearing Screening				PASS	FAIL	REFER
Nose & Throat						
Teeth & Gingiva						
Lymph Glands						
Heart						
Lungs						
Abdomen						
Genitourinary						
Neuromuscular/Extremities						
Spine/Scoliosis						
<b>Psycho-Social Screening</b>				WNL		REFER: Y N

Is the child under treatment ? \_\_\_\_\_ Yes \_\_\_\_\_ No

Does the child have any restrictions on play or physical education activities? \_\_\_\_\_ Yes \_\_\_\_\_ No

Date of Exam \_\_\_\_\_

Signature of Examiner \_\_\_\_\_

Phone \_\_\_\_\_

PRINT name \_\_\_\_\_

## Delaware Valley School District

Dear Parent:

School health law requires all children who are in **grade K, three and seven** to have a complete dental examination.

When the required examination is completed by your family dentist, please have them complete the form below.

If you are on an every six month schedule, please mail this form to your dentist and request it be completed for the last dental visit. **Any exam done within one year of August of this year is acceptable.**

**The students who are not examined by your own dentist will be examined by school dentist.**

We appreciate your cooperation in this program.

School Nurses  
Delaware Valley School District

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### FAMILY DENTIST REPORT

Child's name \_\_\_\_\_ Teacher's Name \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

1. This student last visited my office on \_\_\_\_\_
2. All necessary corrections were made at that time. Yes \_\_\_\_\_ No \_\_\_\_\_
3. If the above answer is no, please indicate the dental correction needed:

\_\_\_\_\_ Primary teeth \_\_\_\_\_ Permanent teeth \_\_\_\_\_ Fillings \_\_\_\_\_ Extractions

\_\_\_\_\_ Gross Malocclusion

\_\_\_\_\_ Prosthetic replacement for lost or missing teeth

\_\_\_\_\_ Other \_\_\_\_\_

This child is currently under my supervision for the above condition. Yes \_\_\_\_\_ No \_\_\_\_\_

4. This child receives topical fluoride applications under my supervision.

\_\_\_\_\_ Yearly \_\_\_\_\_ Every 6 months \_\_\_\_\_ Never

\_\_\_\_\_  
Dentist Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Dentist Address

The following two forms Only need to be filled out, signed, and returned with the packet if you need them.

***A Request for Bus Service to a Licensed Child Care Facility*** form.

And a ***Landlord Affidavit*** form.

(This form is used for proof of residency when you don't own your home or have a signed rental or lease agreement.)

This affidavit must be signed by the landlord and turned in with a copy of the Landlord's property tax bill for that address.

# DELAWARE VALLEY SCHOOL DISTRICT

## REQUEST FOR BUS SERVICE TO A LICENSED CHILD CARE FACILITY

The Delaware Valley School District will consider requests for change of bus assignments to a private child care provider under the following conditions as set forth in Delaware Valley School District Board Policy 810: Pupil Bus Transportation (Section 2 B 6) :

- The request is submitted and signed by the child(ren)'s parent/guardian.
- There is space and continues to be space on the bus.
- The stop is at a Board approved licensed child care facility.
- The stop is used both to and from school.
- The stop is used on all school days including delayed openings and early dismissals.
- The licensed child care facility is listed on the child(ren)'s emergency cards.
- An additional emergency contact is listed for the child(ren).
- The change will require three (3) days to implement.

I authorize the Delaware Valley School District to transport my child(ren) to the licensed child care provider indicated below. I understand that this is a permanent change for everyday, both to and from school. I understand this is the only change from the stop of my residence that will be permitted this year. I will not request any other change for any reason. Also, I understand that overcrowding on the bus to which my child(ren) is/are assigned may cause the Delaware Valley School District to revoke permission for this change.

Signature of Parent/Guardian \_\_\_\_\_ Date: \_\_\_\_\_

Student Name:	Home Address:
School Attending:	Grade:
Home Telephone:	Parent Work Telephone:
Bus Stop Location Nearest Home:	

### REQUESTED TRANSPORTATION ARRANGEMENTS

Licensed Child Care Facility:	Date of Change:
Address of Child Care Facility	Child Care Facility Telephone:
Additional Emergency Contact Name:	Additional Emergency Contact Telephone:
Other Information:	

Return this form to: Delaware Valley Transportation Office      FAX: 570-296-1818  
 258 Routes 6 & 209  
 Milford, PA 18337

**FOR OFFICE USE ONLY**

Date School Notified:	
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# Delaware Valley School District

Office of Support Services -- 258 Route 6 & 209, Milford, Pennsylvania 18337  
570-296-1883 FAX: 570-296-1818

## Affidavit of OWNER/LANDLORD in support of Tenant(s) Proof of Residency

As the OWNER/LANDLORD of the premises described below, I provide this verification in satisfaction of the Proof of Residency requirement for all students enrolling in the Delaware Valley School District. The following persons reside permanently at the address indicated below.

NOTE: No student will be enrolled in any Delaware Valley School until proper Proof of Residency is accepted.

Proof of residency type: \_\_\_\_\_

Tenants: Mr./Mrs./Ms. \_\_\_\_\_

School Age Children: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Tenant's Mailing Address: \_\_\_\_\_  
\_\_\_\_\_

Township of Residence (Attach copy of Current Tax Statement):  
\_\_\_\_\_

Exact location of Residence: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I certify that the information provided in this Affidavit is true and accurate.

\_\_\_\_\_  
*Signature of Owner/Landlord*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Name of Owner/Landlord (Print)*

\_\_\_\_\_  
*Daytime Telephone Number*

**NOTICE:** Individuals signing this form are hereby certifying that the above information is true and correct. False statements contained herein are subject to criminal prosecution under 18 P.C.S.A. Section 4904 related to unsworn falsification to authorities. Penalties for unsworn falsification to authorities include imprisonment for up to one year and fines up to \$2,500.00.